

AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION (Release from CSE)

FOR OFFICE USE ONLY	<input type="checkbox"/> PATIENT GIVES AUTHORIZATION
	<input type="checkbox"/> PATIENT REFUSES TO GIVE AUTHORIZATION

I, (name of patient) _____, (DOB) __/__/__,

Women's college Graduate & Continuing Studies Dates of attendance _____

Authorize College of Saint Elizabeth Health Services to use and/or disclose my health information as identified below to:

- | | | | |
|--|--|---|--------------------------------|
| <input type="checkbox"/> _____
Mother /Guardian | <input type="checkbox"/> _____
Coach | <input type="checkbox"/> _____
Physician | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____
Father /Guardian | <input type="checkbox"/> _____
CSE Athletics Department | <input type="checkbox"/> _____
Faculty | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____
Dean's Office | <input type="checkbox"/> _____
Resident Director/Asst. | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

Records pertaining to: _____

- | | | | | |
|---|--|---|---|--|
| <input type="checkbox"/> medical record | <input type="checkbox"/> physical exam | <input type="checkbox"/> immunization records | <input type="checkbox"/> lab results | <input type="checkbox"/> mental health |
| <input type="checkbox"/> HIV | <input type="checkbox"/> STD | <input type="checkbox"/> substance abuse | <input type="checkbox"/> sexual assault | <input type="checkbox"/> confirmation of visit |

I specifically authorize the use or disclosure of the following health information and/or records, if such information and/or records exist to be sent to:

- Name/Organization: _____
- Address: _____
- _____
- Fax: _____
- Phone Number: _____
- Email (non confidential): _____

Unless revoked earlier, this authorization will expire:

- _____ 365 days from date of signing
- _____ upon the following date (give specific date) _____
- _____ upon the following event (e.g., end of semester; graduation) _____

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I understand that I may revoke this authorization at any time by giving written notice to College of Saint Elizabeth Health Services except to the extent that action has already been taken based on this authorization. I may inspect or copy any information to be used or disclosed under this authorization. I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.

Signature of Individual or Individual's Legal Representative

Date

Print Name of Legal Representative (if applicable)

Relationship of Legal Representative